FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044024

Facility Name: SAINT CLARE HOME

Address: 5533 N. GALENA ROAD (Number) Peoria Heights (City) (Zip Code)

County: Peoria

Telephone Number: (309) 682-5428 **Fax #** ( )

IDPA ID Number: 370813229001

Date of Initial License for Current Owners: 09/01/98

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2003 to 9/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Carolyn Conover
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Craig L. Ater, Senior V.P. and Chief Financial Officer
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,460	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,771	12,124	2,970	31,865	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	365	870	0	1,235	12
13	DD 16 OR LESS					13
14	TOTALS	17,136	12,994	2,970	33,100	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.54%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 09/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,970

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	233,293	21,504		254,797		254,797		254,797			1
2	Food Purchase		172,842		172,842		172,842		172,842			2
3	Housekeeping	102,471	14,503		116,974		116,974		116,974			3
4	Laundry	41,726	15,238		56,964		56,964		56,964			4
5	Heat and Other Utilities			104,641	104,641		104,641		104,641			5
6	Maintenance	63,746	56,088	22,647	142,481		142,481		142,481			6
7	Other (specify):*											7
8	**TOTAL General Services**	441,236	280,175	127,288	848,699		848,699		848,699			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,303,720	138,451	149,796	1,591,967		1,591,967		1,591,967			10
10a	Therapy		121,791	409,857	531,648	(138,630)	393,018		393,018			10a
11	Activities	50,450	1,072		51,522		51,522		51,522			11
12	Social Services	26,733	89	2,400	29,222		29,222		29,222			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,380,903	261,403	565,653	2,207,959	(138,630)	2,069,329		2,069,329			16
	C. General Administration											
17	Administrative	61,208			61,208		61,208		61,208			17
18	Directors Fees											18
19	Professional Services			237,437	237,437		237,437	(1,655)	235,782			19
20	Dues, Fees, Subscriptions & Promotions			93,196	93,196	(51,606)	41,590	(15,147)	26,443			20
21	Clerical & General Office Expenses	184,129	10,690	21,567	216,386		216,386		216,386			21
22	Employee Benefits & Payroll Taxes			557,551	557,551		557,551		557,551			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			6,085	6,085		6,085	(4,086)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,166	26,166		26,166		26,166			26
27	Other (specify):*			40,065	40,065		40,065	(39,984)	81			27
28	**TOTAL General Administration**	245,337	10,690	984,066	1,240,093	(51,606)	1,188,487	(60,872)	1,127,615			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,067,476	552,268	1,677,007	4,296,751	(190,236)	4,106,515	(60,872)	4,045,643			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SAINT CLARE HOME #0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			293,484	293,484		293,484		293,484			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,888	7,888		7,888	(2,494)	5,394			35
36	Other (specify):*											36
37	**TOTAL Ownership**			301,372	301,372		301,372	(2,494)	298,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					138,630	138,630		138,630			39
40	Barber and Beauty Shops			25,024	25,024		25,024		25,024			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,606	51,606		51,606			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			25,024	25,024	190,236	215,260		215,260			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,067,476	552,268	2,003,403	4,623,147		4,623,147	(63,366)	4,559,781			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,494)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(180)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,086)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,655)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,984)	27		24
25	Fund Raising, Advertising and Promotional	(14,967)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,366)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (63,366)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SAINT CLARE HOME

ID# 0044024

Report Period Beginning: 10/01/2003

Ending: 9/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(2,494)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15			33	15
16			24	16
17		(180)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,655)	19	22
23				23
24		(39,984)	27	24
25		(14,967)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(59,280)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SAINT CLARE HOME # 0044024 **Report Period Beginning:** 10/01/2003 **Ending:** 9/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,655)	0	0	0	0	0	0	0	0	0	0	(1,655)	19
20	Fees, Subscriptions & Promotions	(15,147)	0	0	0	0	0	0	0	0	0	0	(15,147)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,086)	0	0	0	0	0	0	0	0	0	0	(4,086)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(39,984)	0	0	0	0	0	0	0	0	0	0	(39,984)	27
28	**TOTAL General Administration**	(60,872)	0	0	0	0	0	0	0	0	0	0	(60,872)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,872)	0	0	0	0	0	0	0	0	0	0	(60,872)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SAINT CLARE HOME **#** 0044024 **Report Period Beginning:** 10/01/2003 **Ending:** 9/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(2,494)	0	0	0	0	0	0	0	0	0	0	(2,494)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,494)	0	0	0	0	0	0	0	0	0	0	(2,494)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,366)	0	0	0	0	0	0	0	0	0	0	(63,366)	45

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V					100.00%			2
3	V								3
4	V					100.00%			4
5	V								5
6	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	100.00%			6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$		100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Heritage Enterprises, Inc.		$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SAINT CLARE HOME COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0044024

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	land			$ 224,000	1
2					2
3	TOTALS			$ 224,000	3

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98				$ 2,682,500	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detector			1999	1,932						9
10	Call Light System			1999	16,785						10
11	Sewage Ejector Pump			1999	3,800						11
12	Door Alarm System			1999	1,275						12
13	Chapel Renovation			1999	1,760						13
14											14
15	Wallpaper/Paint --Remodel Hallways			2000	45,058						15
16	Heat / Cool Pump---Rooftop A/C			2000	8,790						16
17	Corridor Renovation			2000	19,472						17
18	Cubicle Curtains			2000	4,020						18
19	Flooring -- Hallways			2000	45,048						19
20	Rooftop A/C Units			2000	328,932						20
21	Window Treatments			2000	7,221						21
22	Sign			2000	720						22
23	Chapel Renovation			2000	32,210						23
24	Smoke Detectors			2000	3,300						24
25											25
26	Wallpaper/Paint --Remodel Hallways			2001	8,820						26
27	Door Alarm			2001	12,678						27
28	Auto Door Opener			2001	1,919						28
29	Vinyl Floor Coverings -- North and West Wing Rooms			2001	73,863						29
30	Vinyl Floor Coverings -- North and West Wing Rooms --Labor			2001	3,750						30
31	Rooftop A/C Units			2001	88,341						31
32	Flooring -- Hallways			2001	3,418						32
33											33
34											34
35	Book Depreciation					237,906		237,906		1,221,371	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Security Alarm System	2002	$ 15,826	$		$	$	$	37
38	Entry Doors	2002	22,435						38
39	Circulating Pump	2002	4,322						39
40	North Corridor Paint	2002	5,643						40
41	Wallpaper	2002	12,945						41
42	Window Treatments	2002	12,508						42
43									43
44	Phone System	2003	13,908						44
45	North Wing Remodel	2003	888						45
46									46
47	Window Treatments	2004	7,600						47
48	North Wing Remodel Floor coverings	2004	20,882						48
49	North Wing Remodel Painting	2004	21,350						49
50	North Wing Remodel Fire Alarm	2004	44,859						50
51	North Wing Remodel Doors and hardware	2004	15,545						51
52	Water Heaters	2004	60,098						52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,654,421	$ 237,906		$ 237,906	$	$ 1,221,371	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,654,421	$ 237,906		$ 237,906	$	$ 1,221,371	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,654,421	$ 237,906		$ 237,906	$	$ 1,221,371	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 529,324	$ 55,578	$ 55,578	$		$ 397,408	71
72	Current Year Purchases	7,119						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 536,443	$ 55,578	$ 55,578	$		$ 397,408	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,414,864	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 293,484	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 293,484	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,618,779	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,394 Description: pager, computer equipment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 172,682	$		$ 172,682	1
2	Licensed Speech and Language Development Therapist		hrs			35,229			35,229	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			184,857	250		185,107	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				121,541		121,541	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					17,089			17,089	13
14	TOTAL			$		$ 409,857	$ 121,791		$ 531,648	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SAINT CLARE HOME # 0044024 **Report Period Beginning:** 10/01/2003 **Ending:** 9/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 746,218	$	1
2	Cash-Patient Deposits	3,989		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	525,559		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	192,074		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,467,840	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	3,654,420		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	536,444		16
17	Accumulated Depreciation (book methods)	(1,618,779)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,796,085	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,263,925	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,552	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,989		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,199		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,193)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 356,547	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 356,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,907,378	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,263,925	$	48

***(See instructions.)**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,869,664	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,869,664	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	37,714	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 37,714	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,907,378	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,426,657	1
2	Discounts and Allowances for all Levels	(1,176,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,250,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,112,906	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,112,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,683	12
13	Barber and Beauty Care	27,903	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,012	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 242,799	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,972	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,972	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees	28,800	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,800	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,659,791	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	848,699	31
32	Health Care	2,207,959	32
33	General Administration	1,240,093	33
	B. Capital Expense		
34	Ownership	301,372	34
	C. Ancillary Expense		
35	Special Cost Centers	25,024	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(1,070)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,622,077	40
41	**Income before Income Taxes (line 30 minus line 40)****	37,714	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 37,714	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,400	1,751	$ 43,498	$ 24.84	1
2	Assistant Director of Nursing	1,976	2,255	46,522	20.63	2
3	Registered Nurses	3,828	4,123	81,827	19.85	3
4	Licensed Practical Nurses	21,813	24,499	442,368	18.06	4
5	Nurse Aides & Orderlies	55,304	61,691	648,002	10.50	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	807	926	41,503	44.82	8
9	Activity Director					9
10	Activity Assistants	4,522	4,923	50,450	10.25	10
11	Social Service Workers	2,303	2,476	26,733	10.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,853	22,367	233,293	10.43	15
16	Dishwashers					16
17	Maintenance Workers	3,911	4,301	63,746	14.82	17
18	Housekeepers	10,791	11,799	102,471	8.68	18
19	Laundry	3,787	4,237	41,726	9.85	19
20	Administrator	2,000	2,080	61,208	29.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,432	12,490	184,129	14.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,727	159,918	$ 2,067,476 *	$ 12.93	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		3,600		36
37	Medical Records Consultant		1,550		37
38	Nurse Consultant				38
39	Pharmacist Consultant		600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,400		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,150		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 5,312		50
51	Licensed Practical Nurses		48,699		51
52	Nurse Aides		91,089		52
53	TOTAL (lines 50 - 52)		$ 145,100		53

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn Conover	Administrator		$ 61,208
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,208

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management	$ 213,198
OSF Health System	Management	22,584
Rccoupment of Legal		0
Legal fees (Adj to Zero)		1,655
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 237,437

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,220
Unemployment Compensation Insurance	(6,707)
FICA Taxes	158,162
Employee Health Insurance	146,153
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	126,723
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 557,551

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	17,535
Health Care Worker Background Check	
(Indicate # of checks performed)	439
Central Office Allocation	
Promotional Advertising	6,902
Public Relations	8,065
Dues and Subscriptions	7,879
License and Fees	770
Less: Public Relations Expense	(8,065)
Non-allowable advertising	(180)
Yellow page advertising	(6,902)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,443

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,210
	156
Seminar Expense	2,719
	(4,086)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SAINT CLARE HOME **#** 0044024 **Report Period Beginning:** 10/01/2003 **Ending:** 9/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,606**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **9,111**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **Not available at this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount							
1009			PETTY CASH	746,218							1,009	1,009 PETTY CA	746,218			
1010			CASH IN BANK								1,100	1,100 ACCTS RE	525,559			
1040			CASH IN BANK-PAYROLL								1,101	1,101 ALLOW. FOR UNCOLLECTIBLES				
1100			ACCOUNTS RECEIVABLE	525,559							1,110	1,110 ACCTS RECEIV-M/C				
1110			MEDICARE RECEIVABLES								1,125	1,125 ACCTS RECEIV-IPA				
1125			IPA INCOME RECEIVABLE								1,135	1,135 ACCTS RECEIV-IC				
1130			MEDICARE COST REPORT								1,140	1,140 UNAPPLIED CASH RECEIPTS				
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145 A/R SUSPENSE-REFUNDS				
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200 PREPAID I	192,074			
1145			A/R SUSPENSE-REFUNDS								1,220	1,220 OTHER PREPAID EXPENSES				
1190			ACCRUED INTEREST REC								1,300	1,300 DIETARY INVENTORY				
1200			PREPAID INSURANCE	192,074							1,310	1,310 SUPPLIES INVENTORY				
1220			OTHER PREPAID EXPENSES								1,320	1,320 LINEN INVENTORY				
1300			FOOD INVENTORY								1,409	1,409 LAND	224,000			
1310			SUPPLIES INVENTORY								1,450	1,450 FURNITUF	536,444			
1409			LAND	224,000							1,460		-397,408			
1450			FURNITURE & EQUIPMENT	536,444							1,475	1,475 CODE ALE	3,654,420			
1460			ACCUM DEPR-FURN & EQUIP	-397,408							1,490	1,490 ACCUM D	-1,221,371			
1475			BUILDING & IMPROVEMENTS	3,654,420							1,530	1,530 RESIDENT	3,989			
1490			ACCUM DEPR-BUILDING	-1,221,371							1,550	1,550 LOAN FEES				
1530			RESIDENT FUNDS	3,989							1,551	1,551 LOAN FEES ADDED				
1550			LOAN FEES	0							1,850	1,850 INTERCOMPANY				
1560			REAL ESTATE TAX ESCROW								2,010	2,010 ACCOUNT	-128,552			
1575			REIMBURSABLE PURCHASES								2,100	2,095 BONUSES PAYABLE				
1850			INTRACOMPANY	0							2,100	2,100 ACCRUED	-116,379			
2010			ACCOUNTS PAYABLE	-128,552							2,100	2,100 PR CLEARING-BENEFITS				
2095			BONUSES PAYABLE								2,100	2,100 PR CLEARING-LABOR				
2100			ACCRUED PAYROLL	-116,379							2,110	2,110 ACCRUED	-108,820			
2110			ACCRUED VACATION PAY	-108,820							2,120	2,120 U.C. TAXES PAYABLE				
2120			UC TAXES PAYABLE								2,125	2,125 FICA TAXI	1,193			
2125			FICA TAX PAYABLE	1,193	1,193						2,130	2,130 FEDERAL W/H TAX PAYABLE				
2130			FIT PAYABLE								2,140	2,140 STATE W/H TAX PAYABLE				
2140			STATE W/H PAYABLE		0						2,152	2,152 WORKERS COMP ACCRUAL				
2145			EARNED INCOME CREDIT								2,225	2,225 EMPLOYEEE INSURANCE REFUND				
2150			UC FED CREDIT REDUCTION								2,230	2,230 PAYROLL SAVINGS				
2230			PAYROLL SAVINGS								2,235	2,240 UNITED FUND				
2235			IRA W/HOLDINGS								2,240	2,246 GROUP INSURANCE - CAFETERIA				
2240			UNITED WAY								2,246	2,250 401K W/H				
2245			GROUP INSURANCE PAYABLE								2,250					
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260 WAGE GARNISHMENT				
2260			WAGE GARNISHMENTS								2,300	2,300 ACCRUED INTEREST PAYABLE				
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320 IPA PAYMENTS PAYABLE				
2300			ACCRUED INTEREST PAYABLE	0							2,350	2,350 REAL ESTATE TAXES PAYABLE				
2310			SALES TAX PAYABLE								2,385					
2320			IPA PAYMENTS PAYABLE	0							2,400	2,400 CURRENT PORTION OF LT DEBT				
2350			REAL ESTATE TAX PAYABLE	0							2,512	2,512 DUE TO RI	-3,989			
2385			ACTIVITY FUND	0							2,600	2,600 LASALLE BANK #1				
2390			SECURITY DEPOSITS								2,600					
2391			VOLUNTEER FUND								2,625	2,625 LASALLE CONSTR. LOAN #2				
2393			HEART FUND/BAZAAR								2,625					
2395			DEFERRED INC EMP & MEM								2,695	2,695 CURRENT PORTION OF LT DEBT				
2400			CURRENT PORTION LT DEBT								2,720	2,720 RETAINEE	-3,869,664			
2460			INCOME TAXES PAYABLE									net income	-37,714			
2512			DUE TO RESIDENTS	-3,989												
2600			MORTGAGE PAYABLE	0												
2650			EQUIPMENT LOAN PAYABLE									balance	0			
2695			CURRENT PORTION LT DEBT													
2696			DEFERRED INCOME TAXES													
2710			COMMON STOCK													
2720			RETAINED EARNINGS	-3,869,664												
2970			PROFIT/LOSS FOR PERIOD	-37,714												
3007.1			PATIENT DAYS-PRIVATE	12,994										3,007	3,007 PATIENT I	12,994
3007.2			PATIENT DAYS-IPA	17,136										3,007	3,007 PATIENT I	17,136
3007.3			PATIENT DAYS-MEDICARE	2,970										3,007	3,007 PATIENT I	2,970
3007.4			PATIENT DAYS-CONVERSION											3,007		
3007.5			PATIENT DAYS-LICENSED											3,007		
3007.6			PATIENT DAYS-TOTAL											3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-1,808,256		0	0	0	0					3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0					3,010	3,010 BASIC CH.	(1,808,256)
3020		1	BASIC CHARGE-IPA	-1,406,480		0	0	0	0					3,020	3,011 SHELTER (	(1,406,480)
3030		1	BASIC CHARGE-MEDICARE	-945,910		0	0	0	0					3,030	3,030 BASIC CH.	(945,910)
3035		4	DAY CARE/HOME CARE			0	0	0	0					3,040		
3040		1	LIGHT NURSING CARE	0		0	0	0	0					3,050		
3050		1	MEDIUM NURSING CARE			0	0	0	0					3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0					3,061		
3061		1	SKILLED NURSING CARE											3,080	3,080 NURSING	(80,489)
3080		1	NURSING SUPPLIES-PRIVATE	-245,583		0	0	0	0					3,081	3,081 NURSING	(109,843)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0					3,082	3,082 NURSING	(52,012)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0					3,083	3,083 NURSING	(3,239)
3083		1	NURSING SUPPLIES MED PT B											3,100	3,100 DRUGS-MI	(176,376)
3100		17	DRUGS	-209,201		0	0	0	0					3,101	3,101 DRUGS-OT	(32,825)
3101		17	DRUGS-OTHER											3,110	3,110 PHYSICAL	(142,240)
3110		6	PT-PRIVATE	-1,112,906		0	0	0	0					3,111	3,111 PHYSICAL	(27,520)
3111		6	PT-IPA			0	0	0	0					3,112	3,112 PHYSICAL	(214,520)
3112		6	PT-MEDICARE PART A			0	0	0	0					3,113	3,113 PHYSICAL	(134,832)
3113		6	PT-MEDICARE PART B			0	0	0	0					3,140	3,140 LABORAT	(36,442)
3130		1	PUBLIC AID ASSESSMENT INC											3,150	3,150 ST/OT THE	(142,080)
3140		19	LABORATORY INCOME			0	0	0	0					3,151	3,151 ST/OT THE	(6,648)
3150		6	SPEECH/OT-PRIVATE			0	0	0	0					3,152	3,152 ST/OT THE	(242,840)
3151		6	SPEECH/OT-IPA			0	0	0	0					3,153	3,153 ST/OT THE	(165,784)
3152		6	SPEECH/OT-MED PART A			0	0	0	0					3,160		
3153		6	SPEECH/OT MED PART B											3,410	3,410 IPA/OTHEI	338,675
3410		2	IPA DISCOUNTS	1,176,343		0	0	0	0					3,411	3,411 MEDICARI	90,378
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0					3,420	3,420 MEDICARI	722,204
3420		2	MEDICARE DISCOUNTS			0	0	0	0					3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0					3,520		
3520		16	RENT INCOME	0		6	0	6	0					3,530	3,530 BEAUTY S	(27,903)
3530		13	BEAUTY SHOP	-27,903		0	0	0	0					3,560		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0					3,570	3,570 VENDING	(1,476)
3570		12	VENDING INCOME/EXPENSE	-1,683		0	0	0	0					3,590	3,590 EQUIPMEI	(20,428)
3580		12	MANAGEMENT FEES	-28,800		0	0	0	0					3,595	3,595 RESIDENT	(1,379)
3590		1	EQUIPMENT RENTAL	-20,428		0	0	0	0					3,600	3,600 MISC INC(	(2,633)
3595		21	RESIDENT TRANSPORTATION	-1,379		0	0	0	0					4,110	4,110 G&A WAG	176,100
3600		21	MISC INCOME	-2,633		0	0	0	0					4,111	4,111 ADMINIST	61,208
4110			GENERAL & ADMINIST WAGES	176,100	184,129	21	1	17	0					4,115	4,115 G&A PTO (	8,029
4111			ADMINISTRATOR WAGES	61,208	61,208	17	1	0	0					4,120	4,120 EMPLOYE	126,726
4115			VACATION & SICK - G&A	8,029		21	1	0	0					4,125		
4120	4475		EMPLOYEE BENEFITS	126,723	557,551	22	3	0	0					4,130		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0					4,135		
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0					4,250	4,250 OFFICE SU	5,923
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0					4,255	4,255 POSTAGE	4,106
4220			DIRECTORS FEES			18	3	0	0					4,260	4,260 TELEPHON	21,567
4250	4255		OFFICE SUPPLIES	10,690	10,690	21	2	0	0					4,275	4,275 TRAINING	1,999
4260			TELEPHONE	21,567	21,567	21	3	0	0					4,276	4,276 INJURY PR	250
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0 **					4,280	4,280 GENERAL	3,210
4280			GENERAL TRAVEL	3,210	6,085	24	3	16	0					4,281	4,281 MEAL EXP	156
4281			MEAL EXPENSE FOR TRAVEL	156		24	3	19	0					4,285	4,285 EDUCATIC	2,549
4285			EDUCATION & SEMINAR	2,719		24	3	19	-4,086 ***					4,289	4,286 EDUCATIC	170
4290			HELP WANTED ADVERTISING	17,535	93,196	20	3	0	0	-51,606				4,290	4,290 HELP WAN	17,535
4291			PROMOTIONAL ADVERTISING	6,902		20	3	25	-6,902					4,291	4,291 PROMOTIC	6,902
4292			PUBLIC RELATIONS	8,065		20	3	25	-8,065					4,292	4,292 PUBLIC RI	8,065
4300			LICENSES & FEES	52,376		20	3	17	0					4,300	4,300 LICENSE &	52,376
4310			DUES & SUBSCRIPTIONS	7,879		20	3	17	-180					4,310	4,310 DUES & SU	7,879
4320			CONTRIBUTIONS	0		27	3	20	0					4,320	4,340 PASTORAI	0
4350			PROFESSIONAL FEES	1,655	237,437	19	3	22	-1,655					4,350	4,350 PROFESSI	1,655
4355			MEDICAL DIRECTOR	3,600	3,600	9	3	0	0					4,355	4,355 MEDICAL	3,600
4360			UTILIZATION REVIEW			10	3	0	0					4,362	4,362 MEDICAL	1,550
4361			OTHER PHYSICIAN FEES			39	3	0	0					4,363	4,363 PHARMAC	600
4362			MEDICAL RECORDS CONSULT	1,550		10	3	0	0					4,364	4,364 SOCIAL SE	2,400
4363			PHARMACIST FEES	600		10	3	0	0					4,370	4,370 TV RENTA	4,375
4364			SOC SERV/ACT CONSULT	2,400	2,400	12	3	0	0					4,383	4,383 BACKGRO	439
4370			TV RENTAL	4,375		35	3	5	-2,494					4,390	4,390 OTHER TA	1,950
4380			INCOME TAXES		40,065	27	3	26	0					4,400	4,400 PAYROLL	145,102
4383			BACKGROUND CHECKS	439		20	3	26	0					4,401	4,401 PAYROLL	6,353
4400			PAYROLL TAXES	145,102		22	3	0	0					4,410	4,410 GROUP IN	146,153
4401			PAYROLL TAXES ADMINIST	6,353		22	3	0	0					4,420	4,420 LIABILITY	26,166
4410			GROUP INSURANCE	146,153		22	3	0	0					4,430	4,430 WORKMA	131,933
4420			LIABILITY INSURANCE	26,166	26,166	26	3	0	0					4,435	4,435 W/C-FIRST	997
4425			INSURANCE-OWNERS			22	3	21	0					4,436	4,436 DRUG TES	40
4430			WORKMENS COMP INSURANCI	133,220		22	3	0	0					4,450	4,450 MANAGEI	235,782
4450			CENTRAL OFFICE FEES	235,782		19	3	34	0					4,460	4,460 BAD DEBT	39,984
4460			BAD DEBTS	39,984		27	3	24	-39,984					4,461	4,461 BAD DEBT	25,086
4470			LOST ITEMS-RESIDENTS	81		27	3	0						4,470	4,470 LOST ITEM	81
4490			MISCELLANEOUS	0		27	3	0	0					4,475	4,475 UNIFORM	(3)
4510			REAL ESTATE TAXES	0	0	33	3	0	0					4,486	4,486 SERVICE (	7,894
4600			LEASED EQUIPMENT	3,513	7,888	35	3	16	0					4,490	4,490 MISC EXPI	1,962
5110			MAINTENANCE SALARIES	61,329	63,746	6	1	0	0					4,496	4,496 MISC. M.I.	661
5120			MAINTENANCE SICK & VAC	2,417		6	1	0	0					4,510		
5130			ELECTRIC	55,816	104,641	5	3	0	0					4,600	4,600 LEASED E	3,513
5131			NATURAL GAS	45,906		5	3	0	0					5,110	5,110 MAINTEN.	61,329
5132			HEATING & DEISEL OIL			5	3	0	0					5,120	5,120 MAINTEN.	2,417
5133			WATER & SEWER	2,919		5	3	0	0					5,130	5,130 ELECTRIC	55,816
5134			TRASH COLLECTION	1,177	22,647	6	3	0	0					5,131	5,131 NATURAL	45,906
5140			PROPERTY PLANT REPLACEMI	7,075	56,088	6	2	0	0					5,133	5,133 WATER &	2,919
5160			GENERAL REPAIR & MAINT	49,013		6	2	0	0					5,134	5,134 TRASH CO	1,177
5165			MAINTENANCE CONTRACTS	21,470		6	3	0	0					5,140	5,140 PROP/PLA	7,075
5210			DIETARY WAGES	219,268	233,293	1	1	0	0					5,160	5,160 GENERAL	49,013
5220			DIETARY SICK & VAC	14,025		1	1	0	0					5,165	5,165 MAINTEN.	13,576
5240			SALES TAX			2	3	13	0					5,210	5,210 DIETARY '	219,268
5248			FOOD PURCHASES	181,953	172,842	2	2	0	0					5,220	5,220 DIETARY I	14,025
5250			SUPPLIES-DISHWASHING	5,209	21,504	1	2	0	0					5,248	5,248 FOOD PUR	179,991
5260			DIETARY REPLACEMENT	5,585		1	2	0	0					5,250	5,250 SUPPLIES	5,209
5270			KITCHEN SUPPLIES-PAPER	10,710		1	2	0	0					5,260	5,260 REPLACEI	5,585
5295			MEAL CREDIT	-9,111		2	2	0	0					5,270	5,270 KITCHEN	10,710
5310			LAUNDRY WAGES	38,331	41,726	4	1	0	0					5,295	5,295 MEAL INC	(9,111)
5340			LAUNDRY SICK & VAC	3,395		4	1	0	0					5,310	5,310 LAUNDRY	38,331
5370			LAUNDRY REPLACEMENT	8,572	15,238	4	2	0	0					5,340	5,340 LAUNDRY	3,395
5380			LAUNDRY REIMBURSEMENT			4	3	0	0					5,370	5,370 REPLACEI	8,572
5390			LAUNDRY SUPPLIES	6,666		4	2	0	0					5,380	5,380 OUTSIDE I	331
5410			HOUSEKEEPING WAGES	96,177	102,471	3	1	0	0					5,390	5,390 SUPPLIES	6,335
5440			HOUSEKEEPING SICK & VAC	6,294		3	1	0	0					5,410	5,410 HOUSEKE	96,177
5480			HOUSEKEEPING SUPPLIES	5,130	14,503	3	2	0	0					5,440	5,440 HOUSEKE	6,294
5490			HOUSEKEEPING SUPPLIES-PPR	9,373		3	2	0	0					5,480	5,480 SUPPLIES-	5,130
6010			RN WAGES-MEDICARE		1,303,720	10	1	0	0					5,490	5,490 SUPPLIES-	9,373
6020			RN WAGES-NON MEDICARE	82,541		10	1	0	0					6,020	6,020 RN WAGE	82,541
6030			DON WAGES	43,498		10	1	0	0					6,030	6,030 DON WAG	43,498
6035			ADON	46,522		10	1	0	0					6,035	6,035 ADON WA	46,522
6040			RN SICK & VACATION	-714		10	1	0	0					6,040	6,040 RN PTO &	(714)
6110			LPN WAGES-MEDICARE			10	1	0	0					6,120	6,120 LPN WAGI	416,401
6120			LPN WAGES-NON MEDICARE	416,401		10	1	0	0					6,140	6,140 LPN PTO &	25,967
6130			LPN WAGES OTHER			10	1	0	0					6,220	6,220 AIDES WA	587,412
6140			LPN SICK & VACATION	25,967		10	1	0	0					6,240	6,240 AIDES PTC	60,590
6210			AIDE WAGES-MEDICARE			10	1	0	0					6,245	6,245 CONTRAC	5,312
6220			AIDE WAGES-NON MEDICARE	587,412		10	1	0	0					6,246	6,246 CONTRAC	48,699
6230			WARD CLERKS			10	1	0	0					6,247	6,247 CONTRAC	91,089
6240			AIDE VACATION & SICK	60,590		10	1	0	0					6,250		
6245			CONTRACT NURSES-RN	5,312		10	3	0	0					6,255		
6246			CONTRACT NURSES-LPN	48,699		10	3	0	0					6,260		
6247			CONTRACT NURSES-AIDES	91,089		10	3	0	0					6,270	6,270 REHAB W.	37,731
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0					6,275	6,275 REHAB PT	3,772
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0					6,290	6,290 NURSING	81,816
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0					6,295	6,295 NURSING	55,073
6270			REHAB WAGES	37,731		10	1	0	0					6,390	6,390 REPLACEI	1,562
6275			REHAB SICK & VAC	3,772		10	1	0	0					6,490	6,490 OTHER	2,546
6280			NURSING DEPT EDUCATION			23	3	0	0					7,280	7,280 DRUG PUF	88,557
6290			NURSING SUPPLIES	81,816	138,451	10	2	0	0					7,281	7,281 DRUG PUF	32,984
6295			NURSING SUPPLIES	55,073		10	2	0	0					7,380	7,380 LABORAT	8,393
6390			REPLACEMENT-NURSING	1,562		10	2	0	0					7,391	7,390 X-RAY SEI	3,180
6490			NURSING OTHER	2,546	149,796	10	3	0	0					7,393	7,393 OTHER A !	5,516
7280			DRUG PURCHASES	88,557	121,791	39	2	0	0 ***					7,510	7,510 ACTIVITIE	48,162
7281			DRUG PURCHASES-OTHER	32,984		39	2							7,540	7,540 ACTIVITIE	2,288
7380			LABORATORY SERVICES	17,089	409,857	39	3	0	0					7,590	7,590 ACTIVITIE	1,072
7410			HOME HEALTH SALARY			39	1	0	0					7,620	7,620 PHYSICAL	184,857
7440			HOME HEALTH SICK & VAC			39	1	0	0					7,660	7,660 P.T. SUPPL	250
7450			HOME HEALTH EXPENSES			39	3	0	0					7,710	7,710 SOCIAL SE	25,135
7510			ACTIVITES WAGES	48,162	50,450	11	1	0	0					7,720	7,720 SOCIAL SE	1,598
7540			ACTIVITIES SICK & VAC	2,288		11	1	0	0					7,730	7,730 SOCIAL SE	89
7590			ACTIVITIES SUPPLIES	1,072	1,072	11	2	0	0					7,740	7,740 OCCUPAT	172,682
7595			ACTIVITIES FEES	0	0	11	3	0	0					7,750		
7610			PT WAGES			39	1	0	0					7,770	7,770 SPEECH TI	35,229
7611			PT SICK & VACATION			39	1	0	0					7,820	7,820 BEAUTICI	25,024
7620			PT FEES	184,857		39	3	0	0 ***					7,890		
7660			PT SUPPLIES	250		39	2	0	0					7,960		
7710			SOCIAL SERVICE WAGES	25,135	26,733	12	1	0	0					8,120		
7720			SOCIAL SERVICE SICK & VAC	1,598		12	1	0	0					8,125		
7730			SOCIAL SERVICE EXPENSES	89	89	12	2	0	0					8,130	8,130 DEPRECIA	293,484
7740			OT FEE	172,682		39	3	0	0 ***					8,150		
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0					9,510	9,510 INTEREST	(24,972)
7770			SPEECH THERAPY FEE	35,229		39	3	0	0 ***					9,520	9,520 MISC NON	(3,020)
7800			BEAUTICIAN WAGES		0	40	1	0	0					9,530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0							
7820			BEAUTICIAN FEES	25,024	25,024	40	3	0	0							
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0							
7910			VOLUNTEER COORDINATOR			21	1	0	0						3,575 MANAGEI	(28,800)
7940			VOL COORD SICK & VAC			21	1	0	0						3,580 PERSONAI	(207)
7960			VOL COORD SUPPLIES	0		21	2	0	0							
8100			RENT		0	34	3	0	0							(37,714)
8120			INTEREST EXPENSE	0	0	32	3	14	0							
8130			DEPRECIATION	293,484	293,484	30	3	9	0							
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	60,773						
9510			INTEREST INCOME	-24,972		32	0	10	0							
9520			MISC NON-OPERATING INCOM	0		0	0	0	0							
9700			INCOME TAXES	-1,070		0	0	0	0							
				4,597,105	4,623,147											
					26,042											
GRAND TOTALS				-37,714					-63,366							
				(NET INCOME)												
				0												

FACILITY NAME:	
FACILITY ID:	0
FACILITY UNITS:	89
BALANCE SHEET TOTAL	0
	173,113

	G/L	RECAP CENSUS
PP	12,994	12,994
IPA	17,136	17,136
medicare	2,970	2,970
		33,100
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	